

## Needs Assessment for the North Carolina Family Assessment Scales (PIP Item 1B.2.4) Using the NCFAS Results in CPS

Date: August 9, 2010

Author: Ruth Huebner, PhD

**Purpose:** The PIP (Program Improvement Plan) theme of '*Enhancing family involvement and capacity to provide for their children's needs*', highlights Kentucky efforts to improve and expand in-home services for families. One step in that effort is to improve the collaboration between DCBS staff and in-home services provider; these providers also aim to improve parental capacity. Specifically, Kentucky wants to improve the understanding and use of the results of the provider's assessment in DCBS case planning and service provision. To begin, Kentucky will complete an evaluation of staff's knowledge of the *North Carolina Family Assessment Scales* (NCFAS) by PIP Quarter 2 and train staff in the use of NCFAS results by PIP Quarter 4.

### **Background**

The *North Carolina Family Assessment Scales* (NCFAS) are used by all agencies providing in-home services to DCBS clients. Specifically, family preservation, CCC in-home services, and Diversion services all use the NCFAS, NCFAS-G and NCFAS-R to plan intervention and document family progress in safety, parental capacity, environment, child wellbeing, and family interaction. DCBS staff members in the Sobriety Treatment and Recovery Teams (START) program in Jefferson, Martin, Kenton, and Boyd County also use the NCFAS for case planning and to measure change. Additional information relevant to this PIP item is included in Appendix A; excerpts from a comprehensive evaluation of Family Preservation (FP) services, completed in March 2007, including a survey of DCBS staff and the perceptions and satisfaction with FP services.

Information from the NCFAS is rich with understanding of family needs and family progress. If DCBS staff understood the NCFAS and the meaning of the NCFAS, then they could use that information to better serve families in both in-home cases and when reunifying children from OOH.

To assess the use of NCFAS results by DCBS staff, several steps were taken including:

- Brief meeting with the Service Region Administrators (SRA) on January 13, 2010 to describe the needs and seek their input on the best process to determine staff use of NCFAS results.
- Subsequently, the SRA identified a representative from each region to review regional practices and represent the region in a focus group.
- Each regional representative was asked to talk with front line staff and supervisors to determine their level of knowledge of the NCFAS and the use of NCFAS results in case planning or work with families.
- Focus group meeting completed on April 27, 2010. Results are included here.

**Action Step 1B.2.4**

**KY 2<sup>nd</sup> QR PIP report**

**September 30, 2010**

- A follow-up phone conference with regional and CO staff on May 26, 2010.
- Ongoing work with the Family Engagement and Documentation workgroups to use the results of the focus group in action planning for enhancing knowledge and application.

**Action Step 1B.2.4**

**KY 2<sup>nd</sup> QR PIP report**

**September 30, 2010**

### Focus Group/Phone Conference Data Collection

**Objective:** The focus group on April 27, 2010 was designed to develop answers to the questions posed (see page 3), determine if a more full-scale needs assessment was needed, and begin planning for a training/implementation module. The follow-up phone conference on May 26, 2010 was designed to review and clarify the draft report and expand the ideas and discussion.

Twenty-eight participants representing all nine service regions, training, and central office managers attended the intensive focus group. Additional members of Central Office leadership and members of the Family Engagement and Documentation Workgroups contributed to the report and will developed the plan based on the input from the regions.

Name	Division	Name	Service Region
Stacy Hait	CO - Adoptions Branch	Jeff Tarren	Northern Bluegrass
Lucie Estill	CO - OOHC Branch	Cindy Colyer	The Cumberland
Pamela J. Pettry	CO - Adoptions Branch	Jennifer Warren	The Cumberland
Denise Weider	CO - OOHC Branch	Vincent Geremia	SRA Northeastern
Christina Givens	CO - OOHC Branch	Lesia Dennis*	Northeastern
Toya Nicholson	CO - Director's Office	DeDe Sullivan	Salt River Trail
Steve Hartwig	CO - Child Safety Branch	Sandy Mader	Salt River Trail
Dr. Ruth Huebner	CO - IQI	Heather Simpson	Salt River Trail
Lisa Durbin	CO - Child Safety Branch	Kim Donta*	Southern Bluegrass
Gretchen Marshall	CO - QAPD	Erin Smead*	Jefferson
Michael Cheek	Director of Protection and Permanency	Ragena Kinney*	The Lakes
Stacy Carey	CO - Adult Safety Branch	Debra Wilcox-LeMaster	Eastern Mountain
Melissa Jo Wilson	DCBS Training Branch	Ashlee Hale*	Eastern Mountains
Debbie Vonnahme	DCBS Training Branch	Dawn Crabtree*	Two Rivers
Charity Roberts	CO – Family Preservation		
Lynda Robertson**	CO – Family Preservation		
Christa Moore	CCC – Prevention Branch		
Lynne Mason**	CCC – Prevention Branch		
David Gutierrez**	Division of Violence Prevention		
Todd Meade**	CO –Child Safety Branch		

\*Indicates participation in both the focus groups and follow-up phone conference

\*\*Indicates workgroup members not present at the focus group but present in the follow-up phone conference

Action Step 1B.2.4

KY 2<sup>nd</sup> QR PIP report

September 30, 2010

The focus group was held from 11:00 am to 2:30 pm with lunch provided by Central Office Protection and Permanency staff to make efficient use of the time. The condensed time during the middle of the day was set to allow travel time to and from Frankfort for all regional representatives without requiring an overnight stay. The focus group was scheduled as follows:

11:00 – 11:15: Opening remarks: Mike Cheek, Director of Protection and Permanency

11:15-11:45: The NCFAS overview and communication by providers: Charity Roberts, Family Preservation Training Specialist  
Charity reviewed the NCFAS development, domains, scoring of the NCFAS, and expectations of providers.

Between 11:45 and 1:45, the focus group divided the time to discuss these three questions:

- What information are the regions getting from their in-home services providers, how regularly, in what format, and what barriers and opportunities are encountered?
- How do DCBS staff and supervisors currently use NCFAS results and/or provider reports in case planning, assessment, or follow-up services? Are these uses documented?
- What do we want to achieve? What methods and logistics might work best to assist DCBS staff in using the results or report from the NCFAS?

Finally, the meeting focused on making decisions and designing a preliminary plan to improve use of NCFAS results in CPS casework and case planning. The meeting ended promptly at 2:30 pm.

### **Results of the NCFAS Focus Group/Phone Conference**

*What information are the regions getting from their in-home services providers, how regularly, in what format, and what barriers and opportunities are encountered?*

Overall, all groups agreed that FPP workers generally have verbal contact with worker at least weekly with written or formal feedback at the beginning and end of in-home services. Communications comes in phone calls, emails, and sometimes joint visits with the family. However, at times the initial and closing reports from providers are sent at the same time, are too brief to be helpful or informative, and sometimes simply repeat the referral information. The provider reports can be vague and are not as useful in planning. (See also survey results in Appendix A that reinforce the need for improved reports and communication by providers). Providers sometimes fail to get family information from collateral sources (such as schools) to confirm or refine provider's findings; this may create inconsistency in the provider assessment with DCBS assessment because of missing this additional information. There is inconsistent quality and regularity of communication depending on the DCBS services region with some providers providing less frequent communication with varying quality of reports. Providers may not know what DCBS wants or needs from the providers and consequently send feedback that is not helpful or timely.

**Action Step 1B.2.4**

**KY 2<sup>nd</sup> QR PIP report**

**September 30, 2010**

DCBS workers sometimes think that they are free of working with the family during the time of in-home services and focus their attention on other needs. However, DCBS workers need to pay attention to the provider assessment results, question the results, monitor the service provision, and reinforce the work of the in-home providers. It is rare that DCBS workers compare their assessment to the provider's assessment. It is hard to contact the provider with questions. Front line workers do not know what the NCFAS is and know almost nothing about how to read and interpret this.

Some ideas of things that may be helpful:

- An overview with staff on using the NCFAS.
- Improved communication between staff and provider.
- Workers and supervisors trained in NCFAS.
- When in-home services are closing case, hold a closure FTM for discussion of NCFAS ratings and improvements and development of aftercare plan.
- Having community providers come to DCBS and discuss NCFAS with teams.
- Add a section to CQA to discuss NCFAS scores.
- Develop a way for workers and provider to work together on scoring and using the NCFAS.
- Perhaps CO could develop common reporting formats

*How do DCBS staff and supervisors currently use NCFAS results and/or provider reports in case planning, assessment, or follow-up services? Are these uses documented?*

Workers are getting written reports that are placed in the hard copy file. Some do and some do not document that they received the report in the service recordings. Some may include a statement that the family receives in-home services and more often use this statement in the court report to document services. At times the provider reports are too vague to document other than a report is received or service provided. Workers/supervisors don't document the in-home provider reports or the NCFAS results because they don't understand what the information means. Workers tend to use the reports as a documentation of family progress for court reports or to document reasonable efforts but not for DCBS case planning. They may also use the reports to advocate for more services or to change the plan especially if the provider identifies more family risks. There may be mention of the services in the CQA, but the results of the NCFAS assessment are very rarely included in the CQA. The provider's termination or closing summary may be used for aftercare planning.

Workers may not want or really use a written report; they just want to have a conversation about the results. Are things better with the family? Workers have not had formal training on understanding and using the NCFAS. They need to understand the NCFAS, how to use it and interpret it. Because time is a barrier, they are glad to have the in-home service providers' help but don't want more work. The information on the family is usually not available until after the case plan is set. There needs to be more use of the reports in the investigation stage. A few

**Action Step 1B.2.4**

**KY 2<sup>nd</sup> QR PIP report**

**September 30, 2010**

seasoned FSOS (supervisors) use results in case planning but most do not. If the reports are clear and well written, then DCBS workers are more likely to use these. If there were a consistent format for all reports statewide then DCBS would use these more often. There is a special need to know if the family met their goals, how they met goals and if not why not? At closure DCBS needs recommendations for aftercare planning and the specifics of what the family has demonstrated and accomplished.

In the START program, DCBS START team members rate the NCFAS together for each family. This information is then used in reports, case planning, and documented in the CQA. They find this instrument helpful in case planning and in understanding the family needs. However, the staff had to take the time to learn how to score and use the NCFAS.

The group tried to estimate the percent of staff that engage in different practices that show collaboration and use of assessment results of assessment by in-home service providers as a general baseline for the efforts. Results were:

- At least 90% of staff involved with in-home services have regular contact with in-home service providers through phone calls and emails to exchange information on the family's progress.
- 85% of staff involved with in-home services document that the family receives in-home services in case recordings or the CQA.
- 85% include the in-home services report as a hard copy in the case file.
- 50% summarize the report or reference this in court reports or documents
- 25% understand the provider report enough to use it in some aspect of case intervention.
- 10% may know what the NCFAS is or have any idea of how to read or interpret this.
- Very rarely is the use of NCFAS results in case or aftercare planning documented.

Some ideas of things that may be helpful:

- A cross walk between the NCFAS and CQA and case planning
- A section in the CQA to report NCFAS results
- Standardization of in-home service provider reports

*What do we want to achieve? What methods and logistics might work best to assist DCBS staff in using the results or report from the NCFAS?*

If DCBS workers could articulate the progress made in in-home services, it would increase their credibility in the courts. We want to use all the information from providers and DCBS and incorporate this into a comprehensive family focused/specific case plan. To do this, the assessment has to happen early in the case. There needs to be initial and ongoing communication with service providers to discuss expectations including central office and regional level communication.

**Action Step 1B.2.4**

**KY 2<sup>nd</sup> QR PIP report**

**September 30, 2010**

Ideally, the Service provider would complete the NCFAS together with the DCBS staff or at the very least, minimum at the initial or closure for the case. There could be joint DCBS/Service provider training completed in a region-based training. Service providers could attend DCBS staff meetings and supervisor meetings to share information; Northeastern has done this and it was helpful. Because of staff turnover, meetings on-site help to keep communication going and reinforce the training/collaboration.

Tip sheets are needed. The CQA Tip sheet could be updated to include tips on how to use NCFAS results; this can prompt workers. A crosswalk between CQA/NCFAS with a guide to incorporating results in the CQA and case plan. This would support the DCBS work to correctly and thoroughly document NCFAS information in CQA. There are several places the NCFAS information could be documented in the CQA including the summary or other narrative sections.

### Synthesis and Next Steps

The group consensus was that the focus group meeting identified the current state of collaboration with in-home providers and the use of NCFAS results for case planning and working with families. There is no need to do a whole staff survey or other data gathering. A phone-conference on May 26, 2010 and subsequent work group meetings refined the documentation, understanding, and planning.

A multiple phase work plan was identified as a way to achieve the goal of improved collaboration and use of NCFAS results. A theme within the feedback emphasized the opportunity inherent in this PIP item to improve and expand upon the collaboration with the in-home service providers. A consensus was that these ideas should be implemented jointly rather than by DCBS or in-home providers alone. The phases or stages might include one or more of these ideas or suggestions:

- A. Development of tip sheets and other guides such as.
  - a. Tip sheets on how to document the in-home services, reports, and use of NCFAS results created for supervisors and front line staff.
  - b. Cross walks between the NCFAS and CQA to show where the NCFAS information fits.
  - c. Examples of how to include information in the CQA and case plan
  - d. Development of consistent reports from providers so that all staff will know what to look for and where. CO could create a template.
- B. Training and experiential learning – want experiential not didactic training such as
  - a. Mandatory staff training of about 3 hours could be done via CD or videoconference; could be provided by local providers and training coordinators or CO staff. Idea is to build partnership with local providers to let them teach but ensure consistent message and content with oversight.
  - b. Supervisory meetings in the regions are one place to begin. Local providers and CO staff could engage regional supervisors in discussion, training.

**Action Step 1B.2.4**

**KY 2<sup>nd</sup> QR PIP report**

**September 30, 2010**

- c. Overview of the NCFAS provided by the in-home providers to reinforce the partnership.
  - d. Co-scoring the NCFAS on one or two families as training with the local provider; could do initially and at the final scoring.
  - e. Increase the number of times that in-home service providers meet with staff to review the assessment results, provide feedback on the assessment.
- C. Increase collaboration with providers that emphasize the NCFAS such as
- a. Joint FTM meetings about the family
  - b. Meetings early and late in the case not just at the beginning.
  - c. Co-scoring the NCFAS to teach DCBS and to expand collaboration.
  - d. Increase the use of closure meetings since this is so important in aftercare and DCBS involvement. This could include scoring of the family, identifying the specific areas that showed improvements and needs for ongoing support, joint scoring, joint-decision at the termination meeting.
  - e. Clarify the issues around confidentiality and sharing both the CQA and NCFAS between DCBS and local providers.

There has to be a way that these efforts will reduce the workload or improve quality without expanding the workload.

## Appendix A: DCBS Staff Survey on Family Preservation

In March 2007, a survey of front line staff on perceptions and satisfaction with Family Preservation services was completed. Of the 1,697 front-line workers, specialists, supervisors and administrators targeted by the survey, 695 responded, for a response rate of 41%. Some highlights of this survey are:

- On average, respondents had eight years experience.
- The lowest satisfaction ratings dealt with documentations from FPP providers that were useful and helpful in understanding the needs of families.
- Between 58% and 72% of all workers agreed or strongly agreed with each of 15 descriptions of FPP providers' performance as follows:
  - **The FP worker treated the family with respect.**  
83.3% of workers agreed or strongly agreed.
  - **The FP worker maintained confidentiality.**  
81.5% agreed or strongly agreed.
  - **The FP worker listened to my concerns.**  
80.2% agreed or strongly agreed
  - **FP services were started quickly once accepted into the program.**  
77% agreed or strongly agreed
  - **The FP goals for the family were attainable.**  
75.1% agreed or strongly agreed
  - **The FP worker understood the needs of the family.**  
74.6% agreed or strongly agreed
  - **The Family Preservation goals for the family were concrete/understandable.**  
74.5% agreed or strongly agreed
  - **The worker and I worked well together.**  
71.8% agreed or strongly agreed
  - **I am satisfied with FP efforts to facilitate family change.**  
71.2% agreed or strongly agreed
  - **I can reach the worker when I need to.**  
69.9% agreed or strongly agreed
  - **The worker kept me informed about the family.**  
67.2% agreed or strongly agreed
  - **I am satisfied with the communication between FP program and DCBS.**  
66% agreed or strongly agreed
  - **The FP documentation helped me understand the family's progress.**  
61.7% agreed or strongly agreed
  - **The FP worker's documentation met my expectations.**  
59.2% agreed or strongly agreed
  - **The termination letter included useful information about the intervention.**  
57.7% agreed or strongly agreed
- 85% agreed that more FPP services should be more available;

Action Step 1B.2.4

KY 2<sup>nd</sup> QR PIP report

September 30, 2010

- 83% would refer other families to FPP.
- 52% rated FPP workers' understanding of DCBS policy as a barrier at least some of the time.
- 43% identified FPP workers' failure to confront families on high-risk issues as a barrier at least some of the time. 14% rated it as a moderate or strong barrier.